CUSTOMER SERVICE DIVISION
Office locations:

7447 E. Indian School Road, 110
Scottsdale, AZ 85251
or
9379 E. San Salvador Dr., Suite 100
Scottsdale, AZ 85258

Telephone (480) 312-2400
Fax (480) 312-4806

PC 2001

Fee(s)_____

_____
General Provisions
Ordinance to Applicant
Date & Initial

_____
Massage Ordinance to
Applicant Date & Initial

_____
License Number

City of Scottsdale MASSAGE FACILITY APPLICATION

NOTE: ACCURACY IS IMPORTANT — PLEASE TYPE OR PRINT IN INK

To Applicant: Check all your answers for accuracy. False or incomplete answers or omissions may result in non-acceptance, denial or subsequent revocation of a license. If questions are not applicable to you or your business, enter "**N/A**" as a response.

SECTION 1 (Check one) This application is for a:	**SECTION 2** (Check one) Type of ownership:
☐ New License ☐ Renewal of Existing License ☐ Location Transfer ☐ Name Change Only ☐ Information Update	☐ Individual ☐ General Partnership or Limited Partnership ☐ Corporation or Limited Liability Company ☐ Other _____

SECTION 3

1. Applicant: _____ _____ _____
   Last First Middle
2. Business Name: _____
3. All Business Phone(s): _____ Residence Phone: _____
4. Complete Business Address: _____
5. Complete Mailing Address: _____

SECTION 4

1. Name of Local Agent: _____ Phone: _____
2. Complete Address of Local Agent: _____
3. Is the Local Agent a legal resident of the State of Arizona? ___ Yes ___ No
4. List all local on-site manager(s): Submit an additional form if necessary.

Last Name, First Name, MI	Residence Complete Address	Phone Number(s)

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SECTION 5 Individual, General Partnership, or Limited Partnership (*Circle One*) List each owner, partner or member. Attach additional sheets as necessary to disclose additional persons.

1. Each person listed must submit an additional form, fingerprint card and a processing fee.

Title/Position	Last Name, First Name, MI	% Owned	Residence Complete Address

2. Is any person, other than those persons listed in Section 5, Number 1, going to share in the profits/losses of the business? Yes/No (*Circle One*) If Yes, List below:

Title/Position	Last Name, First Name, MI	% Owned	Residence Complete Address

SECTION 6 Corporation/Limited Liability Company/Other _____ (*Circle One*)

1. Name of Business Entity: _____
(Exactly as it appears on Articles of Incorporation or Organization)
2. Date of Incorporation/Organization: _____ State where Incorporated/Organized: _____
3. AZ C.C. File No. _____ Date authorized to do business in Arizona: _____
4. AZ L.L.C. File No. _____ Date authorized to do business in Arizona: _____
5. Is Corp./L.L.C./Other a non-profit? Yes/No (*Circle One*) If yes, give IRS tax exempt number: _____
6. Are you an agent designated by a publicly traded corporation to act on behalf of the corporation under the City of Scottsdale Ordinance? ___ Yes ___ No Are you legal resident of the State of Arizona? ___ Yes ___ No
7. List each officer, member, controlling person or other positions held in the corporation, LLC. If necessary, attach an additional sheet of paper. Each person listed must submit a Massage Facility Supplemental Questionnaire, be fingerprinted, and pay a records check fee.

Title/Position	Last Name, First Name, MI	% Owned	Residence Complete Address

8. If the corporation/L.L.C./Other is owned by another entity, attach a list of each officer, member, controlling person or other position held in the parent entity. Attach additional sheets as necessary to disclose controlling persons in the business. Each person listed must submit a Massage Facility Supplemental Questionnaire.

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License Number

SECTION 7 Creditors/Private Investors/Onsite Manager/Manager (*Circle One*) Attach an addition sheet as necessary to disclose additional person.

List any creditor or person not previously disclosed who owns more than 10% of the beneficial interest in this business.

Title/position	Last Name, First Name, MI	% Owned	Residence Complete Address

SECTION 8 List any other Controlling Person(s) as defined in the attached supplemental information sheet, if not previously listed in section 4, 5, 6 or 7.

Title/Position	Last Name, First Name, MI	% Owned	Residence Complete Address

SECTION 9 Location transfer – **Applicants cannot operate under a location transfer until it is approved by the City**.

1. Previous Business Name: _____
2. New Business Name: _____
   (If applicable)
3. New Business Location: _____
4. Previous Business Location: _____

Planned date of opening at new location: _____ New Business Phone: _____

SECTION 10

Do you own your business location? ___ Yes ___ No Is this a residence? ___ Yes ___ No

Landlord/Property Owner information: Name: _____ Phone #: (_____) _____ - _____

Landlord/Property Owner Complete Address:_____

Do you rent a portion of your business premises to another entity? ☐ Yes ☐ No

SECTION 11

1. Attach a current and complete "All Employee Log" form as provided by the City of Scottsdale Tax & License Registration office.
2. Attach a signed copy of the Certification of Compliance that the facility complies with all requirements listed in the City of Scottsdale Massage Ordinance. This certification is provided by the City of Scottsdale.
3. Attach a Massage Facility Supplemental Questionnaire for each person listed on the Massage Facility application.
   a. Each person must provide a copy of a government issued photo identification (a valid Drivers License or Passport) as proof of age.
   b. Each person must provide proof of U.S. citizenship or lawful residency of the United States authorized to work in the United States. (a copy of a Social Security Card or documentation from the United States Department of Justice, Immigration and Naturalization Service)

I hereby certify that all answers to questions on this questionnaire are true and complete, and I agree and understand that any falsification of material facts may cause forfeiture on my part of all rights to, and consideration to be licensed in the City of Scottsdale, County of Maricopa, State of Arizona.

_____ _____ _____
Print Name Signature Date

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PC 2030

Fee(s)_____

_____
License Number

City of Scottsdale
MASSAGE FACILITY
SUPPLEMENTAL QUESTIONNAIRE

NOTE: ACCURACY IS IMPORTANT — PLEASE TYPE OR PRINT IN INK

To Applicant: Check all your answers for accuracy. False or incomplete answers or omissions may result in non-acceptance, denial or subsequent revocation of a license. If questions are not applicable to you or your business, enter "N/A" as a response.

This questionnaire is to be completed by each controlling person defined in the City of Scottsdale Massage Therapists & Massage Facilities Licenses Ordinance. A controlling person means a person directly or indirectly possessing control of an applicant, licensee or massage facility, and includes an agent and on-site managers. Each controlling person must complete this form, provide a copy of a government issued photo identification as proof of age, provide proof of U.S. Citizenship or lawful residency of the U. S., be fingerprinted and pay applicable fees. Fingerprints must be taken in our office or by a law enforcement agency. If fingerprinted by a law enforcement agency, a letter, on law enforcement agency letterhead, must accompany the fingerprint card stating who identified the individual and obtained the fingerprints.

Check appropriate box:

☐ Owner ☐ Member ☐ Officer
☐ Partner ☐ Agent ☐ Other _____ (title)
☐ Stockholder (___%) ☐ On-site Manager

1. Name of Business: _____ Business Phone: (___)_____

2. Business Address: _____

3. Legal name: _____ Date of Birth: _____
(Last) (First) (Middle) MTH / DAY / YR

All other name(s) previously known as: _____

4. Social Security Number: _____ - _____ - _____ U.S. Citizen? ☐ Yes ☐ No

Are you authorized to work in the United States? ☐ Yes ☐ No

5. Driver's License #: _____ State _____ Expiration Date _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

Describe any scars, tattoos or distinguishing marks: _____

Place of Birth: _____
(City) (State) (Country)

Marital Status: ___ Single Married Divorced Widowed

6.

Complete Current Residence Address:	Complete Current Mailing Address:
What is the state of your legal residency? _____ If AZ, date of residency _____	
Home phone # (_____) _____-_____	Work phone # (_____) _____-_____
Other phone # (_____) _____-_____	Message phone # (_____) _____-_____

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7. Provide your residence addresses for the previous **5 years**. Attach an additional sheet if necessary.

From (MO/YR)	To (MO/YR)	Residence Complete Address	Owned / Rented

8. List your employment and type of business for the previous **5 years**. List most recent first. (Attach an additional sheet if required). Account for all time. **Do not leave any gaps**. If unemployed or a student during a period of time, please indicate.

From (MO/YR)	To (MO/YR)	Name of Business or Employer's Name (Complete Business Address and Phone #)	Position (Title)

9. Have you voluntarily surrendered any license to administer Massage Therapy or a Massage Facility license as a result of, or while under investigation for any reason? ☐ Yes ☐ No If yes, provide specific information below.

Date License Surrendered	*Jurisdiction where license was surrendered*	*License #*	*License Period*

10. Have you had a license for a Massage Facility, to administer Massage Therapy, or a similar license denied or revoked in the State of AZ or any other United State jurisdiction? ___Yes ___ No If yes, provide specific information below.

Date Denied or Revoked	*Jurisdiction where denial or revocation occurred*	*Grounds for Denial or Revocation*

11. Have you or any entity in which you have held ownership, been an officer, member, director, manager or controlling person ever had a business, professional, or Massage Facility application or license rejected, denied, revoked, suspended or fined in this or any other state? ☐ Yes ☐ No If yes, provide specific information below.

Date Rejected, Fined, Denied, Revoked or Suspended	*Jurisdiction where this was rejected, fined, denied, revoked or suspended*	*Grounds for Rejection, Fines, Denial, Revocation or Suspension*

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12. Are you now or have you ever operated or held ownership, been an officer, member, director, manager, or a controlling person of a Massage Facility licensed in this or any other state? Yes ___ No If yes, provide specific information below.

Date of License	*License #*	*Jurisdiction where license was held*

13. Are you delinquent in payment to the City of Scottsdale of any taxes, fees, fines, or penalties imposed or owing out of any business activity owned or operated by you or the Massage Facility? ___ Yes ___ No If yes, provide specific information below.

Type of Delinquency	*License # or Account #*	*Amount of Delinquency*

14. Have you been convicted of a felony; or a misdemeanor involving fraud, theft, dishonesty, assaultive conduct, moral turpitude within 5 years preceding the date of this application? ___ Yes ___ No If yes, provide specific information below.

Date of Offense	*Date of Conviction*	*Offense*	*Where Offense Occurred*	*Courts(s) Entered Into*

15. Have you ever been detained, cited, arrested, indicted or summoned into court for a violation of any law or ordinance (regardless of the disposition even if dismissed)? For traffic violation include only those that were alcohol and/or drug related. ___ Yes ___ No If yes, provide specific information below.

Date of Offense	*Date of Conviction*	*Offense*	*Where Offense Occurred*	*Court(s) Entered Into*

16. Have you ever been convicted, fined, posted bond, been ordered to deposit bond, imprisoned, had sentence suspended, placed on probation or parole for violation of any law or ordinance (regardless of the disposition even if dismissed or expunged)? ___ Yes ___ No If yes, provide specific information below.

Date of Offense	*Date of Conviction*	*Offense*	*Where Offense Occurred*	*Court(s) Entered Into*

17. Are there any administrative law citations, compliance actions or consents, criminal arrests, indictments or summonses pending against you or any entity in which you are now involved? ___Yes ___ No If yes, provide specific information below.

Date of Offense	*Date of Conviction*	*Offense*	*Where Offense Occurred*	*Court(s) Entered Into*

18. Has anyone ever filed suit or obtained a judgment against you in a civil action, the subject of which involved fraud or misrepresentation of a business, professional or Massage Facility license? ___ Yes ___ No If yes, provide specific information below.

Date of Offense	*Date of Conviction*	*Offense*	*Where Offense Occurred*	*Court(s) Entered Into*

19. Are you a registered Sex Offender or required by law to register as a Sex Offender? ___ Yes ___ No If yes, provide specific information below.

Date of Offense	*Date of Conviction*	*Offense*	*Where Offense Occurred*	*Court(s) Entered Into*

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20. As an owner, agent, partner, stockholder, member, officer, manager, or controlling person will you be physically present operating the business of the Massage Facility? _____ Yes _____ No If Yes, how many hours per week? _____

Additional requirements:

1. Provide a copy of a government issued photo identification (a valid Drivers License or Passport.)

2. Provide a copy of proof of U.S. Citizenship or lawful residency of the United States authorized to work in the United States. (Social Security Card or documentation from the United States Department of Justice, Immigration and Naturalization Service.)

I hereby certify that all answers to questions on this questionnaire are true and complete, and I agree and understand that any falsification of material facts may cause forfeiture on my part of all rights to, and consideration to be licensed in the City of Scottsdale, County of Maricopa, State of Arizona.

_____	_____	_____
Print Name	Signature	Date

CERTIFICATION OF COMPLIANCE

License # _____

I, _____, _____ certify that the massage facility
Name Title

_____, located at _____
Business Name Business Address

complies with all of the following minimum requirements set forth in section 16-210:

a) Minimum lighting requirements shall be provided in accordance with chapter 31 of the city code. In addition, at least one (1) artificial light of not less than forty (40) watts, which is not shaded to significantly decrease luminosity, shall be provided in each room or quarters where massage therapy is performed on clients and shall be in use whenever massage therapy is being performed;

b) Minimum ventilation shall conform with chapter 31 of the city code;

c) Adequate equipment shall be provided for disinfecting and sterilizing instruments used in administering or practicing any massage therapy;

d) Closed cabinets shall be provided and used for the storage of clean linens;

e) Except when the client is fully clothed and the massage therapy is administered in a full public view, dressing, locker and toilet facilities, including hot and cold running water, shall be provided for clients as follows: A minimum of one (1) dressing room containing a separate locker for each client, which locker shall be capable of being locked, and a minimum of one (1) toilet and one (1) wash basin. The toilet and wash basin shall be located in the massage facility, or in a public restroom, not used in connection with a commercial business, within 150 feet of the massage facility. If both male and female clients are to be served simultaneously at the massage facility however, a separate massage room or rooms, and separate dressing facilities shall be provided for male and female clients.

f) All walls, ceilings, floors, pools, showers, bathtubs, hot tubs, steam rooms and all other physical facilities for the massage facility shall be in good repair and maintained in a clean and sanitary condition. Wet and dry heat rooms, steam or vapor rooms, steam or vapor cabinets, shower compartments, and toiler rooms shall be thoroughly cleaned each day the business is in operation. Bathtubs shall by thoroughly cleaned after each use.

g) Clean and sanitary towels shall be provided for each client of the massage facility. Each table used for massage therapy shall be provided with a clean and sanitary towel, paper towel or sheet for each client.

h) Compliance with all applicable provisions of the city fire code and zoning ordinance.

_____ _____
Signature Date

All Employee Log As Of ____________
Date

Name of Facility: __________________________ **Facility Address:** ______________________________ **Facility License No.** ___________________

Employee's Full Legal Name: ____________________ ____________________ __________________ ______________________________
Last First Middle Date of Birth

Complete Home Address: ______________________________ ______________________ __________________ ____________________
City State Zip Code

Telephone No. (   ) _______-_______________ **Therapist State License No.** ______________________ **Expiration Date:** ______________________

Employment Position: __________________ **Date Employment Began:** _____________________ **Date Employment Terminated:** ___________

Employee's Full Legal Name: ____________________ ____________________ __________________ ______________________________
Last First Middle Date of Birth

Complete Home Address: ______________________________ ______________________ __________________ ____________________
City State Zip Code

Telephone No. (   ) _______-_______________ **Therapist State License No.** ______________________ **Expiration Date:** ______________________

Employment Position: __________________ **Date Employment Began:** _____________________ **Date Employment Terminated:** ___________

Employee's Full Legal Name: ____________________ ____________________ __________________ ______________________________
Last First Middle Date of Birth

Complete Home Address: ______________________________ ______________________ __________________ ____________________
City State Zip Code

Telephone No. (   ) ________-_______________ **Therapist State License No.** ______________________ **Expiration Date:** ______________________

Employment Position: __________________ **Date Employment Began:** _____________________ **Date Employment Terminated:** ___________

Employee's Full Legal Name: ____________________ ____________________ __________________ ______________________________
Last First Middle Date of Birth

Complete Home Address: ______________________________ ______________________ __________________ ____________________
City State Zip Code

Telephone No. (   ) ________-_______________ **Therapist State License No.** ______________________ **Expiration Date:** ______________________

Employment Position: __________________ **Date Employment Began:** _____________________ **Date Employment Terminated:** ___________

Massage Facility Log Of Massage Therapy Administered

Name of Facility:_____ Facility Address: _____Facility License No. _____

Date	Time	Massage Technique	Name of Therapist (First &Last)	Client's Name (First & Last)	Client's Complete Address
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				
	Am Pm				